

Evans US Army Community Hospital
Exceptional Family Member Program

TO: _____ School District

FROM: _____, parent of _____

1. Enrollment in the Army Exceptional Family Member Program is required for any child of Active Duty Army Soldiers who requires special services from school, whether it be by Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), or Section 504 Accommodation Plan.
2. In order to meet this requirement, I have completed page 1 of the attached form DD 2792-1. Please complete the school's portion of the form on page 2, and provide a copy of my child's most current education plan.
3. Thank you for assisting me with this matter.

Parent signature

Date

**EXCEPTIONAL FAMILY MEMBER
SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY**

*(Page 1 completed by service member or civilian employee.)
(Read Instructions before completing this form.)*

OMB No. 0704-0411
OMB approval expires
Oct 31, 2009

The public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0704-0411). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): To obtain information needed to evaluate and document the special education needs of: (1) Family members of all service members and (2) Family members of civilian employees processing for an assignment to a location outside the United States where family member travel is authorized at Government expense.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude identification of educational needs and the successful processing of an application for family travel/command sponsorship. Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

DEMOGRAPHICS

1.a. APPLICATION STATUS <i>(X one)</i>			b. FAMILY STATUS	
<input type="checkbox"/> INITIAL SCREENING/ ENROLLMENT	<input type="checkbox"/> UPDATED INFORMATION	<input type="checkbox"/> REQUEST DISENROLLMENT	<input type="checkbox"/>	ADDITIONAL FAMILY MEMBERS IDENTIFIED WITH SPECIAL NEEDS

2. IDENTIFICATION	
a. SPONSOR NAME <i>(Last, First, Middle Initial)</i>	b. SSN
c. RANK OR GRADE	
d. BRANCH OF SERVICE <i>(Military only)</i>	e. DESIGNATION/NEC/MOS/AFSC <i>(Military only)</i>
f. HOME ADDRESS <i>(Street, Apartment Number, City, State, ZIP Code)</i>	g. DUTY STATION ADDRESS
	h. OFFICIAL E-MAIL ADDRESS
i. HOME TELEPHONE NUMBER <i>(Include Area Code)</i>	j. FAX NUMBER <i>(Include Area Code)</i>
k. DUTY TELEPHONE NUMBER <i>(Include Area Code)</i>	
(1) COMMERCIAL	
(2) DSN	

3. ARE BOTH SPOUSES ON ACTIVE DUTY? <i>(X one. If Yes, answer a., b., and c. below) (Military only)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> N/A
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a. SPOUSE'S NAME <i>(Last, First, Middle Initial)</i>	b. RANK/RATE	c. SSN
4.a. EXCEPTIONAL FAMILY MEMBER NAME <i>(Last, First, Middle Initial)</i>	b. RELATIONSHIP TO SPONSOR	c. DATE OF BIRTH <i>(YYYYMMDD)</i>

5. DOES FAMILY MEMBER RESIDE WITH SPONSOR <i>(X one)</i>	
<input type="checkbox"/> YES	
<input type="checkbox"/> NO	IF NO, PROVIDE ADDRESS OF FAMILY MEMBER <i>(Include ZIP Code)</i> AND EXPLAIN WHY.

6. IS FAMILY MEMBER ENROLLED IN DEERS <i>(Military only) (X one)</i>	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF YES, UNDER WHAT SSN: _____ FAMILY MEMBER PREFIX _____	

SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO PERSONNEL COMPLETING THIS FORM:

It is important to the military and to the family that the family be assigned to a location that can meet the child's educational needs. Please take care in completing the requested information. (Attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)

1. RELEASE OF INFORMATION (To be completed by sponsor, spouse, or student who has reached the age of majority)

I hereby authorize the release of information on the DD Form 2792-1 and in the attached reports to personnel of the Military Departments. This information will be used only to evaluate and document my family member's need for early intervention or special education services for the purpose of assignment/coordination of my next assignment.

a. NAME OF SPONSOR	b. RANK	c. SSN	d. SIGNATURE OF SPONSOR, SPOUSE, OR STUDENT WHO HAS REACHED THE AGE OF MAJORITY	e. DATE (YYYYMMDD)
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2. DEPENDENT CHILD INFORMATION (To be completed by sponsor or spouse)

a. NAME OF CHILD (Last, First, Middle Initial)	b. CURRENT GRADE LEVEL (If school age)	c. DATE OF BIRTH (YYYYMMDD)	d. AGE (Years/months)	e. SEX (X one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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3. EARLY INTERVENTION PROGRAM (EIP)/SCHOOL INFORMATION (To be completed by representative of EIP or school)

YES	NO	a. IS THE CHILD CURRENTLY BEING EVALUATED FOR SPECIAL EDUCATION OR EARLY INTERVENTION SERVICES?
		b. DOES THIS CHILD RECEIVE EARLY INTERVENTION SERVICES UNDER A CURRENT INDIVIDUALIZED FAMILY SERVICES PLAN (IFSP)? IF YES, DATE OF NEXT ANNUAL REVIEW: ATTACH CURRENT IFSP.
		c. DOES THIS CHILD RECEIVE SPECIAL EDUCATION SERVICES UNDER A CURRENT INDIVIDUALIZED EDUCATION PROGRAM (IEP)? IF YES, DATE OF NEXT ANNUAL REVIEW: ATTACH CURRENT IEP.
		d. IS THE CHILD RECEIVING SERVICES UNDER A SECTION 504 PLAN?
		e. IS THE CHILD BEING "HOME-SCHOOLED"? IF YES, SPECIFY PROGRAM, IF KNOWN:

IF YOU ANSWERED "YES" to questions 3.b. or 3.c., complete Items 4, 5, and 6. Sign and return to sponsor.

IF YOU ANSWERED "NO" to questions 3.a. through d., DO NOT complete Items 4 and 5, but complete Section 6. Sign and return to sponsor.

4. ELIGIBILITY CRITERIA (Indicate the eligibility criteria under which the child is eligible for Early Intervention or Special Education.)

a. IF THE CHILD IS FROM 3 TO 21 YEARS OF AGE:

<input type="checkbox"/> N07 AUTISTIC <input type="checkbox"/> N01 DEAF <input type="checkbox"/> N02 BLIND <input type="checkbox"/> N13 DEAF/BLIND <input type="checkbox"/> N11 VISUALLY IMPAIRED <input type="checkbox"/> N03 HEARING IMPAIRED <input type="checkbox"/> N14 PERVASIVE DEVELOPMENTAL <input type="checkbox"/> N15 DEVELOPMENTAL DELAY <input type="checkbox"/> N08 OTHER HEALTH IMPAIRED (Specify)	<input type="checkbox"/> N09 COMMUNICATION IMPAIRED <input type="checkbox"/> ARTICULATION <input type="checkbox"/> DYSFLUENCY <input type="checkbox"/> VOICE <input type="checkbox"/> LANGUAGE/PHONOLOGY <input type="checkbox"/> N05 TRAUMATIC BRAIN INJURY <input type="checkbox"/> N06 ORTHOPEDICALLY IMPAIRED	<input type="checkbox"/> N04 MENTAL RETARDATION <input type="checkbox"/> MILD/MODERATE <input type="checkbox"/> MODERATE/SEVERE <input type="checkbox"/> SEVERE/PROFOUND <input type="checkbox"/> N12 SPECIFIC LEARNING DISABILITY <input type="checkbox"/> N10 EMOTIONALLY IMPAIRED <input type="checkbox"/> N16 BEHAVIORAL/CONDUCT DISORDER
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b. IF THE CHILD IS FROM BIRTH TO 3 YEARS OLD:

<input type="checkbox"/> DEVELOPMENTAL DELAY	<input type="checkbox"/> HIGH PROBABILITY FOR DEVELOPMENTAL DELAY	c. DISABILITY (Identify if known, e.g., blindness)
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5. SEVERITY OF THE DISABILITY

<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE	<input type="checkbox"/> PROFOUND
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6. PROVIDER/SCHOOL OFFICIAL INFORMATION

a. NAME OF INDIVIDUAL COMPLETING THIS SECTION (Last Name, First Name)	b. TITLE	c. TELEPHONE NUMBER (Include area code)	d. FAX NUMBER (Include area code)
e. NAME OF SCHOOL/EARLY INTERVENTION PROGRAM		f. ADDRESS (Include ZIP Code)	
g. SCHOOL DISTRICT		i. SIGNATURE	
h. E-MAIL ADDRESS		j. DATE SIGNED (YYYYMMDD)	